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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a partial extended complaint investigations #89653, 89883, 91498, 94470, 94612, 94638, 94639, 95223, 96546, 96642, 96928 and 97190. A revised 2567 was sent to the facility on 2/23/16. | F 000 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 176 residents with 11 residents sampled. Based on observation, interview, and record review, the facility failed to review and revise care plans for resident #3 placed in isolation for infection and resident #6 | F 280 | | 3/12/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/22/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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who experienced a significant change of condition with activities of daily living.

Findings included:

- On 2/10/16 review of an Electronic Health Records for resident #3 documented diagnoses that included encounter for palliative care, acute/chronic respiratory failure, stage 1 pressure ulcer of sacral region (large triangular bone between the two hip bones), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), right femur (thigh bone) fracture, history of falls, hypertension (high blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), sleep apnea (sleep disorder characterized by periods without respirations), and polyosteoarthritis (multiple joint degenerative changes characterized by swelling and pain).

Review of the significant change Minimum Data Set Assessment dated 10/12/15 recorded the resident with a BIMS (brief interview for mental status) 10, required extensive assistance with ADLs.

Review of the care plan dated 10/27/15 identified the resident required extensive assistance of two staff for activities of daily living.

Laboratory results of a urinalysis dated 9/5/15 documented the resident with the urinary infection VRE enterococcus faecium infection [vancomycin-resistant enterococcus (Enterococci are bacteria that commonly live in the bowel and are usually resistant to many antibiotics. VRE are

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enterococci that have become resistant to the antibiotic vancomycin.)]

Nursing note dated 9/8/15 at 1:44 pm documented the resident had more than 10 loose stools on this shift.

Nursing note dated 9/8/15 timed 3:02 P.M. recorded physician orders to collect a stool specimen to test for Clostridium difficile [C-difficile a contagious bacteria characterized by foul smelling frequent bowel movement].

Nursing note dated 9/9/15 at 9:57 P.M. documented the laboratory stool sample test came back positive for c-difficile and staff placed the resident on isolation precautions.

A physician visit dated 9/11/15 documented the resident had multiple episodes of diarrhea over last few days.

Review of a physician's history and physical dated 11/12/15 documented in the middle of September, the resident received a 10-day course of vancomycin for c-difficile infection and vancomycin resistant enterococcus urinary infection.

An infection note dated 9/21/15 at 5:10 A.M. documented the resident continued treatment for C-difficile and remained on isolation precautions.

Nursing note dated 11/11/15 at 10:05 A.M. documented the resident experienced multiple episodes of diarrhea and staff administered a physician standing order for antidiarrheal medication at 7:15 A.M.

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Nursing note dated 11/14/15 at 3:03 P.M. documented the resident ' s laboratory report positive for C-difficile.

On 2/12/16 at 6:30 A.M. direct care staff EE reported the resident was in isolation with a cart with supplies outside his/her room, and sign on the door to refer visitors to the nurse.

On 2/12/16 at 6:30 A.M. direct care staff V revealed the resident was in isolation.

On 2/12/16 at 6:30 A.M. licensed nursing staff L reported the MDS coordinator updated the resident's care plans.

On 2/12/16 at 7:30 A.M., direct care staff S reported the resident was on isolation for C-difficile.

On 2/12/16 at 8:04 A.M. direct care staff Q reported the resident was in isolation for c-difficile.

The resident's clinical diagnoses lacked evidence of the diagnoses VRE and C-difficile.

The resident's care plan lacked evidence of the diagnoses of the infectious disease VRE and C-difficile, treatment and precautions.

The facility policy Goals and Objectives, Care Plans dated April 2009 documented care plans included goals and objectives that lead to the resident's highest obtainable level of independent. Goals and objectives were reviewed and/or revised when there has been a significant change in the resident's condition; when the resident had been readmitted to the facility from a

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hospital/rehabilitation stay and at least quarterly.

The facility failed to review and revise the resident's plan care with interventions and treatments for isolation and the resident's contagious infectious agents.

- According to the clinical face sheet the facility readmitted resident #6 on 12/6/15 with diagnoses that included Alzheimer's disease, right femur (thigh bone) fracture, and difficulty walking.

Review of the significant change Minimum Data Set Assessment dated 12/18/15 recorded the resident with short and long term memory impairment, severely impaired decision-making and extensive assistance for all activities of daily living.

The clinical record revealed the resident's care plan for activities of daily living dated 2/2/16 documented the resident was independent for eating, dressing, and grooming after set up assistance from staff. The resident transferred independently, toileted him/herself, and managed his/her own hygiene.

The facility failed to review and revise the resident's comprehensive plan of care after a significant change of status.

Nursing note dated 3/15 2:32 A.M. recorded the results from a mobile x-ray revealed the resident with a right femur fracture from a recent fall on 12/2/15, and staff transferred the resident to an acute care hospital.

Nursing note dated 12/6/15 at 12:28 P.M. documented the resident was readmitted to the

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facility.

Nursing note dated 1/5/16 at 6:27 P.M. documented the resident required assistance from two staff for transfers, and was incontinent of bowel and bladder.

Observation on 2/10/16 at 5:30 P.M. revealed direct care staff M and FF changed the resident's brief, and then transferred the resident from the bed to the wheelchair with a gait belt. Direct care staff M combed the resident's hair and adjusted the residents clothing, then pushed the resident in the wheelchair to the dining room for the meal. Observation revealed, the resident was dependent on staff for all activities of daily living.

During an interview on 2/10/15 at 1:47 P.M. licensed nursing staff G reported the resident required extensive assist of two staff for transfers.

On 2/10/16 at 2:20 P.M. direct care staff Q reported the resident had been on the unit for approximately three months, did not walk, get out of bed, and required two staff for transfers.

The facility policy Goals and Objectives, Care Plans dated April 2009 documented care plans included goals and objectives that lead to the resident's highest obtainable level of independent. Goals and objectives were reviewed and/or revised when there has been a significant change in the resident's condition; when the resident had been readmitted to the facility from a hospital/rehabilitation stay and at least quarterly.

The facility failed to review and revise the resident's plan care with current interventions and treatments after a significant change in status.

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| F 323 SS=H | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES | F 323 | | 3/12/16 |

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 176 residents. The sample included 11 residents. Based on observation, interview, and record review, the facility failed to provide supervision and assistive devices to prevent accidents for 6 of 8 residents reviewed. Resident #7, a cognitively impaired dependent resident identified as a fall risk, from experiencing an avoidable injury fall including multiple rib fractures and a wrist fracture; resident #10, a cognitively impaired dependent resident that experienced multiple falls including an avoidable fall which results in a neck fracture; resident #8 a cognitively impaired dependent resident that experienced a fall that resulted in an inoperable subdural hematoma; resident #11 a cognitively impaired dependent resident dropped from a mechanical lift and experienced a compression fracture of the lumbar spine; resident #1 identified at risk for falls and unsteady balance, transferred without a gait belt as planned, fell and experienced a hematoma; and resident #9 a cognitively impaired dependent resident left unsupervised on a commode for 4 hours and 40 minutes.

Findings included:

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- According to the clinical face sheet, the facility admitted resident #7 on 11/11/14 from an acute care hospital with a cervical (neck) fracture and a history of falls.

Review of the Electronic Health Records on 2/10/16 documented diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), muscle weakness, and difficulty walking.

Diagnoses added on 12/3/15 included multiple fractures of ribs, right side, and fracture of the right wrist.

The quarterly Minimum Data Set (MDS) assessment dated 7/7/15 documented the resident with short- and long-term memory impairment, severely impaired decision-making. The resident required extensive assistance for dressing, walking, toileting, personal hygiene, and bathing. The resident had unsteady balance and was only able to stabilize with staff assistance, functional impairment of range of motion to the upper extremity of one side, used a walker and wheelchair for mobility and experienced two or more non-injury falls since the previous assessment.

Review of the significant change MDS dated 9/23/15 recorded the resident with short- and long-term memory impairment, severely impaired decision-making, rejected cares 4 to 6 days of the assessment period and current behaviors were worse compared to the previous assessment.

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The resident required extensive assistance with activities of daily living except for eating. The resident had unsteady balance and was only able to stabilize with staff assistance, functional impairment of range of motion to the upper extremity of one side used a walker and wheelchair for mobility and experienced one non-injury, and two or more minor injury falls since the previous assessment.

Review of the fall Care Area Assessment (CAA) dated 9/30/15 for documented the resident with significant cognitive losses due to the progression of Alzheimer's disease and he/she required staff assistance with all daily care needs including transfers and mobility. The resident was at risk for falls due to multiple risk factors including significant cognitive losses, long/short term memory problems, poor safety awareness/safety judgements, poor insight into his/her limitations/abilities, and impulsiveness. The resident had episodes of behavioral symptoms, agitation, anxiety, and restlessness, which add to his/her risk for falls. The resident had a decreased ability to communicate his/her needs to staff including when he/she needed to use the toilet, and when he/she had pain due. Staff had tried multiple interventions to decrease the risk for falls and the resident had recently been working with physical and occupational therapy to increase his/her strength and improve overall ability to participate in transfers.

The cognition CAA dated 9/30/15 documented the resident with difficulty making decisions, impaired judgment, impaired thought processes, and required assistance with all activities of daily living.

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The behavior CAA dated 9/30/15 recorded the resident had significant cognitive losses due to the progression of Alzheimer's disease. The resident had frequent episodes of resistance/refusal of care, which included striking out/hitting out at staff, restlessness, agitation, grabbing at staff, refusing to take medications, and refusing to eat. The resident had episodes of agitation, anxiety, and inability to communicate his/her needs to staff, which placed the resident at risk for behavioral symptoms. In addition yelling out "help" or hollering, the resident could become physically combative with staff during care, refused to eat/take his/her medications, and became restless. Staff implemented multiple non-pharmacological interventions to attempt to decrease behavioral symptoms; however, interventions were not always effective.

Fall Assessments reviewed included the following:
11/12/14 scored (18) high risk for falls
1/19/15 scored (23) high risk for falls
4/14/15 scored (16) high risk for falls.

The fall risk assessment dated 6/10/15 recorded a score of (16), which placed the resident at high risk for falls. This assessment documented the resident experienced 1 to 2 falls in the last 6 months, exhibited loss of balance while standing, strayed off the straight path of walking, required hands on assistance to move from place to place, and used and an assistive device for mobility.

Fall risk assessment continued:
7/15/15 scored (15) high risk for falls
7/24/15 scored (23) high risk for falls
7/30/15 scored (24) high risk for falls
10/8/15 scored (20) high risk for falls

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10/15/15 scored (19) high risk for falls
11/5/15 scored (20) high risk for falls
11/13/15 scored (19) high risk for falls

The fall risk assessment dated 11/29/15 recorded a score of (25), which placed the resident at high risk for falls and documented multiple falls in the last 6 months. The resident was unable to stand independently, exhibited loss of balance while standing, required hands on assist to move from place to place, exhibited jerking or instability when making turns, used an assistive device for mobility and had a decrease in muscle coordination.
A fall risk assessment dated 12/2/15 scored (27) high risk for falls.

The resident ' s plan of care dated 2/18/15, identified the resident was at risk for falls related to significant cognitive losses (long and short term memory problems, poor safety awareness, poor insight into limitations, abilities, can be impulsive). The resident exhibited increased anxiety/agitation, decreased mobility to right shoulder, frequent episodes of urinary incontinence, hearing loss, and decreased ability to communicate needs to staff, and a history of falls. The plan of care included the following dated interventions:
11/12/14 Antiroll backs added to the wheelchair
12/30/14 move resident ' s bed against the wall
2/19/15 document if the resident reported pain using 0-10 scale as resident is able to report it; use mild to severe scale if resident was unable to rate pain or use estimate of pain with nonverbal signs and symptoms of pain. The resident received scheduled analgesics (pain mediation) and oral medication for pain, and has a PRN (as needed) medication for breakthrough pain.

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6/10/15, staff to re-direct and bring the resident to day area when restless
7/24/15, address need for scheduled pain med to decrease anxiety
8/10/15, check last on rounds; if restless do not lay back down
8/13/15, when restless, toileting should be first intervention
9/30/15, physician to evaluate and treat
10/3/15, bed controls Velcro to end of bed. The resident required one to one for mobility and dependent care. The resident could self-propel in the wheelchair at times. The resident required one to one extensive assistance for transfers.
10/8/15, evaluate sleep/wakefulness, schedule for 7 days.
10/15/15, slipper nonskid socks or shoes at all times.
10/19/15, monitor bruising until resolved to back of left hand
11/5/15, staff on 11pm/7am shift to change sides during med pass so both halls are covered
11/13/15, when resident ' s [family member] leaves, place resident in wheelchair
11/29/15, soft touch call light pinned to mattress when in bed
12/2/15, transfer the resident from wheelchair to recliner right after meals
12/4/15, uses standard wheelchair
12/9/15, resident may use Broda chair (specialized wheelchair with the ability to tilt and recline) for comfort PRN (as needed).

The plan of care for skin care and pressure ulcer prevention dated 10/8/15 documented a toileting program, habit/scheduled at: 2:30 A.M. - 3:00 A.M., 4:30 A.M. - 5:30 A.M., 6:30 A.M. - 7:30 A.M., 10:00 A.M. - 11 A.M., 3:00 P.M. - 4:00 P.M., 5:30 P.M. - 6:30 P.M. Staff toileted the resident if

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he/she was awake on night rounds, otherwise use a check and change method. Staff provided one to one extensive assistance with toileting.

The November 2015 physician order sheet signed 11/16/15 directed staff to check the resident's wireless bed and chair alarms for proper function and placement every shift.

The resident's care plan last updated 12/2/15 lacked this intervention.

Nursing note dated 7/24/15 at 1:21 A.M., recorded the staff found the resident laying on the floor mat on his/her right side next to the window near the bed. A nursing assessment revealed injuries to the resident ' s arm, elbow, shoulder, hip, and knee, all on the right side. The resident complained of pain in his/her right arm and staff offered PRN pain medication. The skin assessment revealed multiple skin tears above and below the resident's right elbow; abnormal discoloration on the resident's right shoulder, upper right arm, right knee, ribs, and right hip; and an abrasion on the right knee.

A fall investigation dated 7/24/15 1:18 A.M., documented staff took the resident to restroom at about 1:00 A.M. and he/she tried to get out of bed on his/her own. The resident was very nervous, agitated at times, alert to self with confusion, would not follow directions, and had mild weakness in all extremities.

The fall audit recorded the resident already with alarms, and staff needed to address the resident ' s anxiety related to pain.

Nursing note dated 7/25/15 at 3:45 A.M.

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documented the resident tried to climb out of bed without staff assistance. Two staff attempted to help resident into wheelchair, but the resident pushed staff away and attempted to get behind the wheelchair. Staff guided the resident into the wheelchair for safety due to his/her unsteady gait and weak/shaking legs. Staff placed the resident in the living area and placed the resident one to one with staff for safety.

Nursing note dated 8/10/15 at 5:40 A.M., the resident's alarm sounded while staff was doing rounds. When staff entered the room, they observed the resident sitting on his/her bottom on the floor mat next to his/her bed. The resident was unable to state what happened. Staff assisted the resident up to bed with no apparent injuries.

Nursing note dated 8/12/15 at 1:45 P.M. recorded a physical and occupational therapy evaluation and treatment for falls.

Nursing note dated 8/13/15 at 11:15 P.M., documented at about 9:15 P.M., during the shift change narcotic count, direct care staff T went to answer the resident's alarm. Direct care staff T assisted the resident back in bed. After shift count, nursing staff assisted another staff with a resident who was a two-person assist. Approximately 10 minutes after shift count, nursing staff heard the resident's alarm again and found the resident on the floor in his/her room. Staff observed the resident on his/her hands and knees, hand up on the windowsill, trying to stand and put him/herself back to bed. The resident complained of right hip, shoulder and right sided back pain. The resident said he/she had to go to the bathroom and reported he/she could stand.

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Staff assisted the resident to the toilet and returned the resident to bed. Nursing staff notified the physician and received ordered to send the resident to the emergency room for evaluation of right hip and right sided back pain after a fall.

An emergency room discharge transfer form dated 8/14/15 documented the resident with a contusion (bruise) of the left hip; and compression fracture of lumbar vertebra (portion of the spinal column between the ribs and pelvis).

A quarterly nursing assessment note dated 9/26/15 at 4:23 A.M., documented the staff attempted to redirect the resident and at times provided 1:1 supervision for safety. The resident required one to one assistance with transfers and toileting.

Nursing note dated 9/30/15 at 6:24 A.M., documented the resident sat in the day room recliner with one to one staff assistance. During early morning, the resident slept and staff attempted to make rounds while the resident slept. Nursing staff heard a noise and found the resident out of the recliner on his/her right side. The nursing assessment revealed the resident had a raised area on forehead.

The facility fall investigation lacked evidence of a root cause for the resident's fall.

The fall audit report recorded the staff had not placed a chair alarm.

A physician progress note dated 9/30/15, documented the resident fell out of a chair and obtained a 5 cm by 3.5 cm hematoma on the left frontal/lateral temple scalp hematoma; area with

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ecchymosis (bruising) present, approximately 1 cm in height. The resident has had recurrent falls and advanced dementia with behaviors.

Nursing note dated 9/30/15 at 1:27 P.M., recorded the resident had no complaints of pain or discomfort, however staff administered scheduled pain medication.

Nursing note dated 10/1/15 at 11:09 A.M. documented a follow up from the resident's fall and assessed the resident with a bruise to right side of forehead, purple color measured 7 cm by 4.5 cm. Another bruise identified on the resident's right elbow, purple in color, measured 2.5 cm by 2.6 cm.

Nursing note dated 10/15/15 at 1:07 A.M., at 12:20 A.M. direct care staff notified licensed nursing staff on another unit, he/she needed assistance due to resident getting up and needing help. Upon arrival to the unit at 12:30 A.M., licensed nursing staff observed the resident on the floor. Direct care staff had answered the resident's request for toileting and then laid the resident back down. While the direct care staff went to assist another high fall risk resident who was wandering, the resident's bed alarm sounded. Direct care staff ran down to help the resident and found him/her standing next to his/her bed and he/she fell as direct care staff entered the room. Direct care staff reported the resident fell backwards, his/her bottom hit the bed, rolled back and hit his/her back on the headboard, then slid off the bed and hit his/her head on the window ledge. Nursing staff assessed the resident with pinkness to the right shoulder blade and administered as needed pain medication for the resident's back pain.

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The fall audit dated 10/15/15 documented the resident was not brought to the television area and included the intervention of slipper socks.

Nursing notes dated 10/16/15 at 2:09 P.M. recorded a physician visit with new orders that include: laboratory tests; increase of the medications, Buspar (antianxiety medication) to 10 milligram (mg) three times daily for agitation; Trazodone (antidepressant medication used to treat anxiety) 25 mg at bedtime for agitation/combativeness/dementia; and Tramadol (pain medication) to 50 mg three times daily for chronic pain.

Review of a behavior note dated 10/26/15 at 3:15 A.M. recorded staff provided one on one supervision for the resident after administering as needed medications for anxiety/pain and resident's continued attempts to get out of his/her wheelchair.

Nursing note dated 11/5/15 at 7:59 A.M., recorded at 6:40 A.M. staff found the resident on the floor. Nursing note recorded the medication aide passed medications and direct care staff answered call lights, both on the east hall (opposite hall the resident resided on). Nursing staff administered the resident's medications at 6:10 A.M., and offered toileting, which the resident declined. Nursing staff documented the new intervention for falls, was for direct care staff to come to the south hall while the medication aide was on the east hall passing medications, for safety.

The fall audit dated 11/5/15 documented education to night shift staff of switching sides of

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the hall at medication administration times.

Nursing note dated 11/13/15 at 6:29 P.M. documented at 4:40 P.M. the resident attempted to stand from the recliner in the day area, fell to his/her knees and rolled on his/her left side. The resident immediately attempted to stand up. The resident had been visiting with his/her [family member] approximately 5 minutes before the fall. Staff offered toileting to the resident and he/she refused. Nursing staff documented the new intervention for falls, was to assist the resident into the wheelchair when his/her family left.

In an untimed communication note to the physician on 11/13/15, the physician responded to discontinue the wireless bed and chair alarms and place the resident on 15-minute checks.

On 11/29/15 at 2:19 A.M. nursing staff documented that direct care staff found the resident on the floor in his/her room after staff rounded on the other resident hall.

The fall investigation dated 11/29/15 at 2:17 A.M., recorded staff checked on the resident approximately 5 minutes prior to the fall. Staff documented the resident was anxious, confused and calling out.

The fall audit form documented the intervention of a soft touch call light pinned to side of mattress to alert nursing staff of resident trying to get up.

Nursing note dated 11/29/15 at 5:02 P.M. documented when checking on the resident, he/she was standing, holding onto the window ledge, exposed his/her [genitals], and was urinating on the floor. This staff member came up

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behind the resident slowly and braced his/her hips against the resident trying not to startle him/her (to prevent a fall). The resident was agitated with this intervention and staff had to call for additional staff to help assist the resident back to bed.

The nursing note lacked evidence the soft touch call light activated to alert staff when the resident stood up from bed.

A physician note dated 11/30/15 documented the resident with advanced dementia with episodes of agitation and combativeness in the evenings.

Nursing note dated 12/2/15 at 10 A.M., documented guests observed the resident walking across living area without assistance. The resident attempted to sit in a recliner, missed the recliner, fell backwards slowly, and then rolled to his/her left side. Nursing staff documented the new intervention to prevent falls, was to transfer the resident out of the wheelchair right after meals.

The fall audit report documented the new intervention to prevent falls, for staff to toilet the resident and put in recliner after meals.

The clinical record documented the resident with a fall on 12/2/15 at 9:05 P.M.

Nursing note dated 12/3/15 at 12:55 A.M. recorded at 9:05 P.M. staff reported the resident with an unwitnessed fall in the living room. Staff observed the resident on the floor in front and to the left of a Broda chair on his/her right side. The resident complained of pain in the right wrist and held his/her wrist, stating "oww" . The resident

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refused to let staff perform range of motion on the right wrist, arm, and shoulder due to pain.

Nursing staff notified the physician and at 9:40 P.M. received orders for immediate x-rays of the resident's right shoulder and right wrist due to pain related to a fall.

The fall investigation documented the nurse and a direct care staff assisted a resident that required two staff assistance and the other direct care staff assisting a resident in a room, and left the resident unattended.

The fall investigation recorded nursing staff observed the resident in the Broda chair in living room most of evening and was last observed at 8:45 P.M. The incident occurred at 9:05 P.M. Staff documented the resident held his/her right arm and wrist repeating "oww" , "ugg" and would not use or allow anyone to touch his/her arm. The resident remained in a wheelchair next to nursing staff from 9:10 P.M. to 11:15 P.M., and constantly attempted to stand and ambulate independently.

The fall audit report documented the new intervention included, Broda (specialized wheelchair with the ability to tilt and recline) chair for comfort, recliner after meals, and pain management.

The stat mobile x-ray report 12/2/15 timed 11:56 P.M., documented the resident with acute right lower rib fractures and degenerative joint disease (degenerative changes to one or many joints characterized by swelling and pain) of right shoulder. The resident had a right wrist fracture.

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Nursing note dated 12/3/15 at 3:07 A.M. documented the results of the resident ' s x-rays at 1:00 A.M. The physician and responsible party, upon notification, made the decision to send the resident to the emergency room for treatment at 7:00 A.M. nursing staff administered PRN pain medication at 11:11 P.M. and the resident remained seated in the recliner with staff in the living area.

Nursing notes dated 12/3/15 at 12:00 P.M. documented the resident returned from the emergency room at approximately 11:15 A.M. with a sling to the right arm.

In a statement on 12/2/15 at 9:05 P.M. direct care staff BB reported the resident sat in a Broda chair in the evening. Direct care staff BB did not witness the resident's fall as he/she assisted another resident to bed.

On 2/12/16 at 6:20 A.M. licensed nursing staff I reported the resident's alarms were discontinued. Licensed nursing staff I reported nursing staff kept the resident close to the desk at night for supervision to anticipate his/her needs, as the resident was impulsive and had frequent falls. Licensed nursing staff I reported he/she covered two separate units and at times covered three separate units.

On 2/12/16 at 4:00 P.M. direct care staff T reported the resident sat in a Broda chair after the evening meal. The resident was more lethargic (drowsy, sluggish, inactive) and in the commons area. Some of the times, the resident required one on one staff supervision to prevent falls. Just prior to the resident's fall on 12/2/15 at 9:05 P.M., the other two staff on the unit, a nurse and direct

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care staff, were in a room transferring a resident with a mechanical lift. Direct care staff T reported he/she was watching the residents in the common areas when an unsampled resident got up and decided to go to bed. When this resident decided to go, staff had to assist this resident to prevent him/her from falling. While assisting the unsampled resident in his/her room, direct care staff T reported he/she could peek out the door at the other residents several times and the resident remained in the Broda chair. However, when he/she came out of the room, the resident was on the floor. The resident laid on his/her right side and held his/her wrist.

The facility provided policy Fall Prevention and Management dated February 2014, documented when the resident expressed a need, the staff should assist the resident promptly or immediately find another staff member that can perform the task for the resident. It was the responsibility of all staff to stay alert to these specific residents and report to the nursing staff immediately when a high-risk resident was or attempted to ambulate or transfer without assistance. The policy directed that staff performed an assessment to identify contributing factors for the fall. Staff conducted a post-fall huddle, involving all staff from the neighborhood, to identify causative factors and develop interventions to reduce the risk of further falls, and continue to ask "why" until staff identified a root cause. Staff communicated fall occurrence and interventions implemented to all pertinent staff.

The clinical record revealed from 7/1/15 to 12/20/15, the resident experienced 9 falls.

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The facility failed to provide supervision and assistive devices to prevent this cognitively impaired dependent resident identified as a fall risk, from experiencing an avoidable injury fall including multiple rib fractures and a wrist fracture.

- Review of resident #10's Electronic Health Records documented diagnoses that included dementia with behaviors [progressive mental disorder characterized by failing memory, confusion accompanied by sleep disturbances, delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), hallucinations (sensing things while awake that appear to be real, but the mind created), and verbal or physical outbursts, general emotional distress, restlessness, pacing, and shredding paper or tissues], psychosis (any major mental disorder characterized by a gross impairment in reality testing), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), psychosis (any major mental disorder characterized by a gross impairment in reality testing), and a history of falls.

The quarterly Minimum Data Set (MDS) Assessment dated 4/28/15 recorded the resident with a Brief Interview for Mental Status (BIMS) 7, which indicated severe cognitive impairment. The resident required extensive assistance from staff for transfers, bed mobility, dressing, toileting, and personal hygiene. The resident exhibited unsteady balance and required staff to stabilize, used a wheelchair for mobility, and experienced 2 or more non-injury falls since the prior assessment.

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The significant change MDS dated 9/27/15 recorded the resident with a BIMS score of 5, which indicated severe cognitive impairment, exhibited behaviors, rejected care and required extensive assistance for ADLs. The resident experienced 2 or more non-injury falls since the previous assessment and was recently admitted under hospice services.

Review of the cognition Care Area Assessment (CAA) dated 10/20/15 documented the resident had a diagnosis of dementia, at risk for decline in intellectual functioning.

Review of the falls CAAs dated 10/20/15 documented the resident with the potential for falls and injury related to his/her history of recent falls, impaired cognition, impaired mobility, required extensive assist of two staff with transfers, incontinence, psychoactive medications, and medical diagnoses. The resident had a history of multiple falls with an increased risk of future falls. Staff would develop a care plan to monitor and provide interventions needed to prevent injuries.

Review of the behaviors CAA dated 10/20/15 documented the resident had a long history of mental illness and the progression of dementia which brings out some inappropriate behaviors.

The quarterly MDS dated 12/22/15 documented the resident with a BIMS score of 3, required extensive assistance with ADLs and experienced 2 or more non-injury falls.

Review of the fall assessments 5/29/15, 7/15/15, 7/20/15, 8/4/15, 8/29/15, 9/4/15, 10/2/15, 12/1/15, 12/18/15, 12/23/15, 1/28/16 (revealed scores of

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19-28) high risk for falls, and indicated a total score greater than 10 placed the resident at high risk for falls.

Review of the care plan dated 1/28/16 identified the resident was at risk for injury related to falls and injury with multiple risk factors related to progression of dementia, memory loss, chronic pain, use of medications. The plan of care included the following:
On 12/18/14 Perimeter mattress to bed.
Noninjury fall on 5/29/15 with the intervention low bed.
Noninjury fall 7/15/15 directed staff not to lay resident down when agitated and moved the bed against the wall.
An injury fall resulting in bruising to back on 7/20/15 [and hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on forehead] directed staff to place a mattress on the floor beside the bed.
Noninjury fall on 8/4/15 added a flat call light in resident ' s room.
Noninjury fall on 8/29/15 ordered and completed a hospice consult.
Noninjury fall on 9/4/15 (twice) directed staff not to leave resident alone when the resident was trying to get up and staff should use the call light to ring for assistance.
Noninjury fall on 10/2/15 (no intervention recorded on the care plan).
Noninjury fall on 10/22/15 directed a hospice completed a medication review.
Noninjury fall on 12/1/15 (no intervention recorded on the care plan).
Intervention on 12/18/15 removed the perimeter mattress to bed.
Noninjury fall on 12/23/15 nonskid socks and toilet the resident prior to lying him/her down.

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Noninjury fall on 1/10/16 directed staff to encourage resident to get up for all meals, provide 15-minute checks if he/she refused to get up for breakfast.
Injury fall on 1/28/16 resulted in a cervical fracture C2-T4 with facial bruising directed staff to provide one on one care twenty-four hours a day.

Additional interventions added on 12/28/15 included Velcro the bed controls to the end of the bed, transfer bar on the left side of the bed, provide one to one extensive assistance with transfers, one to one dependent care for mobility with a standard wheelchair.
Document the resident ' s pain per his/her report or estimate using nonverbal cues.
Administer antianxiety and antidepressant medications as physician ordered.
Administer antipsychotics mediation as physician ordered.
Administer scheduled and PRN (as needed) pain medication as physician ordered.

The plan of care for behaviors dated 1/28/15 directed staff the resident did well with one to one, assist with brushing hair, applying makeup, "talk him/her down from anxiety episodes", or use music. The resident's anxiety appeared to decrease with music and singing, and he/she enjoyed singing songs from musicals such as Sound of Music and Oklahoma. Assign consistent caregiver to provide resident cares.

A nursing note dated 7/15/15 at 8 A.M., recorded at 7:30 A.M. the resident experienced an unwitnessed fall and staff found the resident on the floor sitting on his/her bottom, three feet from the bed. Nursing staff assessed the resident with no new injuries and then transferred the resident

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from the bed to the wheelchair and positioned the resident in the hallway next to medication cart.

The facility investigation dated 7/15/15 at 7:30 A.M. documented at approximately 5:30 A.M. the resident received PRN Ativan (antianxiety medication) for agitation and yelling out. Nursing staff transferred the resident to bed at 6:45 A.M., and reported the resident was asleep in bed at 7:05 A.M. Nursing staff then found the resident on floor 2-3 feet from bed. The resident stated, "My mother is still under there" and looked at the bed. The investigation documented the resident was agitated, confused, yelling at staff, and would not stay in one place. Staff implemented the intervention to move the resident ' s bed against the wall.

The investigation lacked evidence of a root cause analysis of the resident ' s fall.

Nursing note dated 7/20/15 at 10:04 A.M., documented at approximately 8:00 A.M. nursing staff observed the resident sleeping in bed. At 8:45 A.M. staff found the resident on the floor and before finding the resident on the floor, staff heard the resident yelling, "Come get me!" Nursing staff had entered the room to get the resident out of bed. Staff found the resident lying on his/her left side with his/her feet under the bed and his/her head resting on the wheel of wheelchair. The resident was awake, kept saying, "I hit my head" , and was holding his /her forehead. Nursing assessment revealed a large hematoma on the resident ' s forehead. Nursing staff obtained a physician and sent the resident by ambulance to an acute care hospital for evaluation.

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The facility investigation dated 7/20/15 at 8:45 A.M. recorded the resident fell/crawled out of bed and went to an acute hospital by ambulance. The investigation failed to address the resident's head injury. Staff implemented the intervention to declutter the resident ' s room and place a mattress on the floor next to the bed in place of the fall mat.

The facility investigation lacked a root cause analysis of the residents fall and injury.

Nursing note dated 7/21/15 at 11:29 A.M. recorded a physician order to monitor the bruise on the resident's face.

Nursing note dated 7/22/15 at 6:36 A.M. in a fall follow up recorded the resident with weakness in both upper and lower extremities.

Nursing note dated 7/22/15 at 11:26 A.M. recorded the resident continued with facial bruising and complained of a headache. Nursing staff administered PRN pain medication, which was effective.

Nursing note dated 8/4/15 at 6:55 P.M. recorded at approximately 3:30 P.M. staff found the resident sitting on the mattress on the floor next to the bed. Nursing staff transferred the resident to a wheelchair and brought the resident out to the television area with other residents and he/she continued yelling out. Nursing staff attempted to offer the resident a snack, drink, and activity, which the resident refused. Nursing staff administered PRN anxiety medication. Nursing staff recorded new interventions to place a flat call light for resident use and add the resident to the list for medication review.

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The resident's plan of care lacked evidence of the intervention of the medication review.

The facility failed to identify this event on the fall logs provided dated 7/1/15 through 2/6/16.

Nursing note dated 8/29/15 at 3:10 P.M. recorded staff found the resident on the mattress beside his/her bed during rounds, and assessed without an injury.

The fall investigation dated 8/29/15 at 2:55 P.M. documented staff last observed the resident at 2:00 P.M. and at shift change, found the resident out of bed. Staff assisted the resident to the wheelchair and brought him/her out to the hall.

The investigation lacked evidence of a root cause of the resident's fall.

Review of the fall audit dated 8/29/15 documented the resident with increased agitation and anxiety and recorded the intervention to speak with the family again about a room change or hospice services.

Nursing note dated 9/3/15 at 6:04 A.M. documented at 4:45 A.M. staff heard the resident screaming out while in bed. Nursing staff went to resident room and asked the resident if he/she was in pain, and the resident yelled "YES". Nursing staff administered PRN pain medication and the anxiety medication. The resident continued to yell. Direct care staff provided one to one monitoring with the resident until licensed nursing staff could complete the morning medication pass. Nursing staff then transferred the resident to the wheelchair and sat with the

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resident one on one in the nursing office.

Nursing note dated 9/3/15 at 6:39 A.M. documented the resident was pinching him/herself on inner left upper arm. Nursing staff redirected him/her and the resident did stop pinching his/her arm.

Nursing note dated 9/4/15 at 2:11 P.M. recorded the resident with an unwitnessed fall resident and he/she appeared to have crawled out of bed. Nursing staff implemented the intervention to educate staff on not leaving resident to get extra help but to use call light to notify staff of the need for help.

The fall investigation dated 9/4/15 at 1:30 P.M., documented nursing staff went to look for assistance to transfer the resident, and the resident climbed onto the mattress on the floor. The fall investigation lacked evidence of a root cause of the resident's fall.

The clinical record revealed on 9/15/15 hospice services admitted the resident with the diagnosis senile degeneration of the brain (mental deterioration associated with aging).

Nursing note dated 10/2/15 at 6:34 A.M., documented at approximately 6:00 A.M. staff heard the resident yelling and found the resident scooting on the floor beside the mat on floor in front of the bed. Two staff members assisted the resident to the restroom where he/she was incontinent of bowel. Staff then transferred the resident in a wheelchair, placed the resident at the nursing station for one on one supervision, administered physician ordered antianxiety and pain medications.

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The post fall supplement plan of care, provided by the facility, documented an intervention for visual checks every 30 minutes for 72 hours.

The resident's care plan lacked evidence of this intervention.

Review of the fall audit note dated 10/2/15 revealed the nursing staff on the unit was unaware of the resident ' s routine.

The fall investigation dated 10/2/15 AT 6:00 A.M., documented at an unknown time; staff last observed the resident resting in bed. The fall investigation revealed the unit had new staff assigned who were not familiar with the resident's routine.

The fall investigation lacked evidence of a root cause for the resident's fall.

Nursing note dated 10/22/15 at 4:06 A.M. recorded at approximately 3:30 A.M. staff observed the resident lying on floor beside the mattress. The resident yelled, screamed, and kicked at staff when asked what happened and refused to let staff assist transfer him/her off the floor.
The fall investigation dated 10/22/15 at 3:30 A.M. documented the resident with increased confusion and agitation and refused to let nursing staff help him/her off the floor. Documented as the new intervention was a medication review and evaluation by hospice staff.

The fall investigation lacked evidence of a root cause of the residents fall.

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The fall audit note dated 10/22/15 recorded the intervention for hospice evaluation of the residents increased agitation and restlessness and staff were to get the resident up when he/she was restless.

Nursing note dated 12/1/15 at 10:00 A.M., recorded at approximately 10:00 A.M. staff observed the agitated resident sitting on the floor. The resident stated, "I was trying to get up". Two staff members assisted the resident with a gait belt and to the toilet and the resident was incontinent of urine.

The post fall supplement plan of care dated 12/1/15 documented the intervention resident is to come out for meals and activities if awake and anxious. The resident was refusing to get up for breakfast.

The fall audit report dated 12/1/15 recorded the new intervention for staff to offer assistance in getting resident up by 9:00 A.M.

The fall investigation dated 12/1/15 at 10 A.M., documented the resident had confusion, bilateral lower extremity weakness and attempted to get up. Staff observed the resident between one and three hours before in bed sleeping (without a specific time). Staff found the resident sitting on the floor, refused care and yelled at staff to "leave him/her alone".

The fall investigation lacked evidence of the root cause of the resident's fall.

A quarterly nursing note dated 12/22/15 at 1:57 P.M. recorded the resident required extensive one to one assistance with transfers, dressing,

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toileting, and showers. The resident was incontinent of bowel and bladder and staff followed a toileting schedule with prompted toileting every 2 hours and then check and change every 2 hours at night. The resident tried to get up without assistance and had multiple falls.

Nursing note dated 12/23/15 at 8:08 P.M. documented at approximately 7:55 P.M. nursing staff found the resident half on and half off his/her mattress. The resident lay on his/her back with legs on the mattress and upper torso on floor. The resident yelled, "Help me up!" Three staff members assisted the resident up with use of a gait-belt, and transferred the resident into a wheelchair. Staff brought the resident out to the hallway to have one on one supervision.

The fall audit report dated 12/23/15 recorded the intervention to toilet the resident before laying him/her down.

The fall investigation dated 12/23/15 at 7:55 P.M. documented approximately one to three hours prior, the resident sat in a recliner in the television room. The fall investigation recorded the resident appeared to roll onto a mattress on floor and continued to crawl half-off the mattress on the floor.

The fall investigation lacked information if staff transferred the resident from the recliner to the bed and lacked evidence of a root cause of the residents fall.

Nursing note dated 1/11/16 at 1:12 P.M., staff found the resident sitting on the mat beside the bed. The resident stated, "I was trying to get up".

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Staff assessed the resident for no injury and then transferred the resident to a wheelchair. A new intervention to help prevent falls directed staff to encourage the resident to get up for meals, and if he/she refused, reproach and try again.

The fall investigation dated 1/11/16 at 12:30 P.M. recorded staff found the resident sitting on the floor mat. Staff last observed the resident one to three hours earlier sleeping in bed.
The fall investigation lacked evidence of a root cause analysis for the resident's fall.

Nursing note dated 1/28/16 at 10:54 pm, recorded after the evening meal, the resident was yelling out and nursing staff placed the resident in his/her wheelchair next to the medication cart to do one on one. The resident calmed and staff assisted other residents with ADLs. While in a resident ' s room, nursing staff heard his/her name called by another staff and found the resident lying on the floor on his/her left side with a skin tear to the left forehead. Nursing staff obtained a physician order and sent the resident to an acute care emergency room for evaluation and treatment.

The facility fall investigation recorded two unsampled residents witnessed the resident's fall.

The investigation lacked evidence of statements from the witnesses.

The facility fall investigation lacked evidence of the root cause of the resident's fall.

Nursing note dated 1/29/16 at 3:59 P.M. documented the resident returned from the hospital at 2:53 P.M.

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Nursing note dated 1/30/16 at 4:07 A.M. recorded the resident expressed pain and received physician ordered pain medication. Staff performed one on one observations of the resident.

Nursing note dated 1/30/16 at 1:16 P.M. documented staff assessed the resident with continued with discolorations to the left eye, top of head, back of left hand and the resident frequently complained of pain. New physician orders directed staff to discontinue scheduled pain medications and new orders for the narcotic pain medication Roxanol 5 milligrams every hour as needed for pain.

A physician note dated 2/1/16 recorded the resident with a fall on 1/28/15 and experienced a laceration and spinal fracture of the neck. Physician orders directed the soft collar neck brace could be worn or not, and to remove sutures in ten days.

Nursing note dated 2/2/16 at 10:43 A.M. recorded the resident refused to wear the soft collar, continued to have multiple bruising to the face and hands due to the recent fall, and had a one to one caregiver.

Nursing note dated 2/5/16 at 6:20 P.M. documented the resident was increasingly agitated, moaning in pain, and repeatedly sat up in bed grabbing at his/her neck and head. The one to one sitter reported to nursing the resident appeared to be very uncomfortable. Nursing staff observed the resident sitting up (in bed), moaning inaudibly and held his/her left hand on the left side of his/her head. Nursing staff administered

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the physician ordered antianxiety and pain medications.

Observation on 2/10/16 at 9:00 A.M. revealed the resident lay quietly with eyes closed in a low bed with a soft flat call pad positioned within reach. The resident had a large crescent moon shaped closed laceration on the left forehead.

In a statement on 1/28/16 at 9:24 P.M., direct care staff Z revealed he she did not observe the resident fall. Direct care staff Z and staff Y assisted a resident who required two staff assistance. When staff came out of the unsampled resident's room, the resident lay on the floor.

In a statement on 1/28/16 direct care staff Y revealed he/she and direct care staff Z attended another resident and came out of the room to observe the resident with a laceration on his/her head lying on the floor in the hallway while a licensed nursing staff assessed the resident.

On 2/10/16 at 9:00 A.M. direct care staff AA revealed he/she was assigned to sit with the resident one on one to make sure the resident did not fall when he/she tried to get up.

On 2/10/16 at 4:40 P.M. licensed nursing staff F revealed he/she was charting in the nursing station and heard a resident screaming for assistance. Licensed nursing staff F observed the resident lying face first on the floor and it appeared he/she had fallen out of his/her wheelchair.

On 2/11/16 at 8:40 A.M., direct care staff S reported staff had provided one on one since

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his/her last fall (1/28/16).

On 2/11/16 at 7:30 A.M. direct care staff S reported the resident attempted to get up and walk independently. The resident received scheduled antianxiety and pain medications, which were effective. The resident required one staff with a gait belt to transfer to the toilet. Approximately 15 minutes before the resident fell, he/she sat in a wheelchair at the nursing station next to the medication cart. The nurse at the medication cart would watch the resident.

On 2/12/15 at 9:00 A.M. direct care staff U reported the nurse at the medication cart watched the resident at the hallway on the unit.

On 2/12/16 at 9:10 A.M. licensed nursing staff J revealed the resident frequently rolled out bed onto the mattress, was restless, had anxiety, and was never care planned for one to one supervision before the fall. When the resident was hollering out and moving around in the wheelchair he/she should have had one to one supervision to prevent his/her fall from the wheelchair.

On 2/12/16 at 3:45 P.M. licensed nursing staff K reported the resident usually sat in a wheelchair in the hallway by the medication cart for staff to keep an eye on him/her. After the evening meal, approximately 7:00 P.M., the resident was anxious and staff brought him/her down to the normal spot at the desk and the medication cart. After a time, the resident appeared relaxed and sat quietly in the wheelchair and staff went to perform a treatment on another resident. Licensed nursing staff revealed someone called out and he/she went into the hall and observed

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the resident on the floor with a C-shaped skin tear on his/her forehead. Licensed nursing staff obtained a physician order to send the resident to an acute care hospital for evaluation and treatment. The resident returned and the facility and staff implemented one to one supervision.

The facility provided policy Fall Prevention and Management dated February 2014, documented when the resident expressed a need, the staff should assist the resident promptly or immediately find another staff member that can perform the task for the resident. It was the responsibility of all staff to stay alert to these specific residents and report to the nursing staff immediately when a high-risk resident was or attempted to ambulate or transfer without assistance. Staff performed an assessment to identify contributing factors for the fall. Staff conducted a post-fall huddle, involving all staff from the neighborhood, to identify causative factors and develop interventions to reduce the risk of further falls and continue to ask "why" until staff identified a root cause. Staff communicated fall occurrence and interventions implemented to all pertinent staff.

The facility failed to provide supervision and timely and effective interventions for this cognitively impaired dependent resident, identified as a fall risk, who experienced multiple falls including an avoidable fall, which resulted in a neck fracture.

- The Electronic Health Records documented diagnoses for resident #11 that included a history of falls, and dementia (progressive mental

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disorder characterized by failing memory and confusion).

The significant change Minimum Data Set Assessment (MDS) dated 1/13/16 recorded the resident with a BIMS (brief interview for mental status) 6, which indicated severe cognitive impairment. The resident required extensive assistance of two staff members for all activities of daily living, and functional loss of range of motion of one lower extremity. The resident experienced unsteady balance, was only able to stabilize with staff assistance, used a wheelchair for mobility, and experienced no falls since the previous assessment.

Review of the Care Area Assessment for falls dated 1/13/16, documented the resident with a potential for falls with injury related to a history of falls, impaired mobility, memory loss, extensive assist with transfers, total assist with Broda chair (specialized wheelchair with the ability to tilt and recliner) for mobility, urinary incontinence, progression of dementia. The resident had no recent falls but was at increased risk of future falls due to his/her medical diagnoses and conditions. Staff would develop a care plan to provide interventions for fall prevention.

The Fall Assessment dated 1/16/16, scored (12), which placed the resident at moderate risk for falls.

The plan of care dated 1/22/16 identified the resident at risk for injury due to fall history and multiple other factors. The resident required total assistance from two staff with transfers and a full body lift and small sling.

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Nursing note dated 2/5/16 at 10:40 P.M., recorded staff reported to the licensed nurse that the resident fell from the lift onto the floor. Licensed nursing staff identified the resident on a blood thinner Coumadin, complained of upper back pain, notified the primary care physician, and obtained a physician order to send the resident to an acute care emergency room for evaluation and treatment.

Nursing note dated 2/5/16 at 11:59 P.M., recorded the hospital emergency room determined the resident had a compression fracture (when forced together bone surfaces caused a bone to break) of the upper back (lumbar vertebra L1 of the back), and sent the resident back to the facility.

Review of a facility investigation dated 2/8/16 documented while transferring the resident with a full body lift, the resident fell to the floor and direct care staff Z and CC placed the resident into bed and then notified the nurse. The facility removed the lift from service and requested a maintenance inspection. The maintenance inspection on 2/8/16 found the lift in good operational and physical condition. The wheel brakes locked and the lift safely supported, raised, and lowered a 260-pound male staff member. Maintenance services placed the lift back into service.

The post fall supplemental plan of care to prevent further falls, dated 2/5/16 recorded interventions for staff to perform pain assessments and staff education.

The facility investigation lacked evidence of a root cause analysis of the resident's fall.

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Observation on 2/11/15 at 12:15 P.M. revealed the resident sat quietly in a Broda chair waiting for lunch service.

A statement from direct care staff Z on 2/5/16 at 9:15 P.M. revealed when transferring the resident from a Broda chair (specialized wheelchair with the ability to tilt and recline) into bed with direct care staff CC, he/she controlled the full body lift. When he/she leaned down to move the blanket and sheet off the bed, he/she heard a loud bang asked the other staff what happened. Staff observed the resident was on the bar on the floor. Staff moved the resident from the floor to the bed to provide personal cares.

A statement from direct care staff CC on 2/5/16 at 9:15 P.M., revealed while using the full body lift, the resident was in the air in the lift and as staff moved the blanket out of the way, the bar sling broke. The resident fell to the floor and staff moved him/her off the bar on the floor and placed the resident in the bed to change the resident ' s incontinence brief.

A statement from licensed nursing staff F on 2/5/16 at 9:15 P.M., reported the direct care staff reported the resident had fallen out of a mechanical lift. Licensed nursing staff F found the resident in bed when he/she went to assess the resident. The resident presented with a distressed look on his/her face and when asked if he/she experienced pain, the resident stated "yes, my back". The nursing assessment revealed the resident had a red discoloration to his/her upper back.

On 2/10/16 4:38 P.M. direct care staff M reported two staff always managed mechanical lifts for

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residents and he/she had received training on use of the lift.

On 2/12/16 at 3:45 P.M. licensed nursing staff K revealed both direct care staff Z and CC reported the mechanical lift broke and the resident fell to the floor. Direct care staff Z came from another unit in the facility and was inexperienced on this unit. Licensed nursing staff K reported maintenance found nothing wrong with the mechanical lift and reported direct care Z's unit did not use mechanical lifts. Licensed nursing staff K reported the resident confirmed he/she hit his/her head and exhibited facial grimacing while the staff obtained his/her blood pressure. Nursing staff received a physician order and transferred the resident to an emergency room for evaluation and treatment. The hospital notified the facility the resident had a compression fracture of the L1 lumbar vertebra (the portion of the spinal column between an individual ' s ribs and pelvis).

According to the facility provided resident transfer list, direct care staff Z's home unit did not have residents that required a transfers with a mechanical lift.

The facility provided policy Transfer and Lift dated 9/3/13, documented the facility ensured that all staff members received instruction for safe transfers and lifting techniques and how to report suspected injuries. Facility staff was trained on the use of transfer and lifting equipment before they first used the equipment. Staff made sure all equipment or assistance was available. There must be two staff members for lifting non-weight bearing residents. Staff used the equipment as designed to be used, safely, with attention, and with good body mechanics.

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The facility failed to provide supervision and assistive devices for this cognitively impaired dependent resident in a manner to prevent an avoidable fall from a mechanical lift that resulted in an injury and compression fracture of the lumbar spine.

- Review of resident #1's Electronic Health Records on admission 4/10/15 documented diagnoses that included peripheral vascular disease (abnormal condition affecting the blood vessels), lack of coordination, difficulty walking, and personal history of fall.

A change of physician History and Physical dated 6/10/15, documented the resident ' s medical problems originally began the end of March 2015 through 4/10/15 for treatment of acute respiratory failure and mechanical ventilation.

Review of the Medicare 5-day MDS Assessment dated 6/13/15 recorded the resident with a BIMS score of 15, which indicated intact cognition. The resident required limited assist from staff with activities of daily living. The resident exhibited unsteady balance and was only able to stabilize with staff assistance. The MDS documented the resident without falls since the previous assessment.

Review of the fall risk assessment dated 6/16/15, documented a score of (13) and indicated a total score of 10 or greater placed the resident at high risk for falls.

The resident ' s plan of care dated 6/6/15

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identified the resident at risk for injury related to falls, history of falls, injury, and multiple risk factors. The care plan identified the resident on the falling star program and directed staff to ensure proper non-slip footwear that fit well and were in good condition, nonskid socks, low boy bed, and monitor the need for pain management.

The plan of care for activities of daily living deficit updated 5/10/15 documented the resident required one on one assistance with transfers. Intervention added on 5/14/15 directed one on one assistance with the resident to ambulate from the wheelchair to the toilet and back to the wheelchair. Intervention added on 6/15/15 directed staff to assist the resident to walk to dine.

A nursing admission note dated 4/10/15 timed 7:34 P.M. recorded the resident stated the reason for admission was "my fall at home a few days ago". Nursing staff documented the resident was physically unable to stand or sit for orthostatic (taken in the supine, sitting, and standing positions to assess for changes of position causing low pressure) blood pressure measurements due to his/her bedbound status.

A skilled nursing assessment dated 6/14/15 at 10:03 A.M. documented the resident was alert and oriented. The resident received physical and occupational therapy, exhibited an unsteady gait, and lower extremity weakness that affected balance. The resident required extensive assistance from one staff for transfers, toileting, mobility, and used a manual wheelchair.

Nursing note dated 6/16/15 at 8:35 A.M., recorded nursing staff at the nursing station heard

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a loud noise in the dining room and found the resident lying on the floor with direct care staff DD at the resident ' s side. The resident reported he/she attempted to pull out a chair from the table to sit down and was unable to pull the chair, and lost his/her balance. Nursing note recorded direct care staff DD ambulated with the resident from his/her room to the dining room with the front-wheeled-walker without a gait belt on the resident for safety. Nursing assessment revealed a raised hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on the back of the resident's head, which measured 3.5 centimeter (cm) by 3.2 cm. The resident reported he/she hit his/her head on the floor and reported pain in his/her left shoulder and right heel. Nursing staff contacted and received orders from the primary care physician for an x-rays to evaluate the resident's fall.

Nursing note on 6/16/15 at 3:27 P.M. documented x-ray results were negative for fracture.

The facility investigation dated 6/16/15 at 8:35 A.M. documented the direct care staff neglected to put a gait belt on the resident when ambulating.

Review of the fall audit report dated 6/16/15 recorded staff failed to apply a gait belt when ambulating with the resident.

A Post Fall Supplemental Care Plan directed to educate staff to pull out chair for resident and educate staff to use a gait belt when ambulating at all times.

Nursing note dated 6/17/15 at 10:48 A.M., revealed the resident reported pain with palpation

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(a technique used in physical examination in which the examiner feels the texture, size, consistency and location of certain body parts with his/her hands) of the raised area on the back of his/her head.

A nursing note dated 7/20/15 at 8:03 A.M. recorded physical therapy to discharge the resident per the resident ' s choice. Physical therapy recommended long-term are for the resident secondary for the need for constant assistance with transfers and if patient returning home, recommendations included 24-hour assistance, 7 days a week for transfers and ambulation.

The discharge summary dated 7/21/15 documented the resident required limited assistance of one staff for activities of daily living, ambulated with assistance of one staff and a walker, and used a wheelchair for long distances.

On 2/12/16 at 6:30 A.M., direct care staff V revealed the resident walked with a walker and required one to one staff assistance with a gait belt for all transfers and ambulation.

On 2/12/16 at 6:30 P.M., licensed nursing staff L revealed the resident did not always want to follow safety precautions with using the call light and ambulation.

On 2/12/16 at 11:54 P.M. administrative nursing staff C reported staff always used a gait belt with one to one staff/resident assistance.

On 2/12/16 at 12:55 P.M. administrative staff A reported staff should use a gait belt with all resident transfers including ambulation.

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The facility policy Transfers and Lifts dated 9/3/13 documented the facility would ensure that all staff members were instructed in safe transfer and lifting techniques and how to report suspected injuries. The policy directed staff to know the residents' needs. The care plan should be very explicit on exactly how staff were to transfer or lift the resident. Know the resident's weight bearing status and balance problems.

The facility failed to provide safe transfers and assistive devices of a gait belt as planned for this resident identified with a history of falls and unsteady balance to prevent an avoidable fall that resulted in a head hematoma.

- Resident #8's electronic health records identified the resident with diagnoses that included amputation of right great toe, muscle weakness, glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), and vascular dementia (progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).

Review of the intra-agency transfer from an acute care hospital dated 10/30/15, documented the resident with poor safety awareness, non-weight bearing to the right lower extremity with a post-op shoe and amputation of the right great toe on 10/27/15.

Review of the 5-day Medicare readmission Minimum Data Set Assessment dated 11/6/15 recorded the resident with a Brief Interview for

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Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. The resident required extensive assistance with activities of daily living, except supervision with eating and limited assistance with personal hygiene. The resident experienced falls in the previous 2 to 6 months and had functional loss of range of motion to one lower extremity. The resident required a wheelchair for mobility and exhibited unsteady balance, and was only able to stabilize with staff assistance. The resident was continent of urine (anuric, the absence of urine formation due to kidney failure) and frequently incontinent of bowel and not on any toileting program. The resident experienced falls in the last two to six months prior to readmission.

The Care Area Assessment for falls dated 11/9/15 documented the resident was at risk for falls due to a recent right great toe partial amputation and was no weight bearing on the right lower extremity.

Review of the Fall Assessment dated 10/11/15 recorded a score of 12, which placed the resident at moderate risk for falls.

A fall assessment completed on 12/19/15 recorded a score of 21, which placed the resident at high risk for falls. The fall assessment documented the resident with severely impaired vision, multiple falls in last three months, unable to obtain a standing position independently, exhibited loss of balance while standing, and required hands on assistance from staff to move from place to place.

The resident's plan of care dated 11/13/15 recorded the resident at risk for injury related to

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falls, a history of falls, multiple risk factors, poor judgment/safety awareness, weakness, use of psychotropic or other meds, impaired balance, and reduced vision. The plan of care recorded an intervention on 11/9/15 to move the resident closer to the nursing station.
The plan of care directed the resident required extensive assistance of two staff for transfers, weight bearing as tolerated with the post-op shoes, used a rolling walker and standard wheelchair. Staff left the door open to monitor the resident except with privacy needs. The resident required a low boy bed.
Intervention added on 12/19/15 directed staff to increase visual checks to every 15 minutes for two hours after the resident ' s [family] left.
Interventions added on 12/21/15 directed no black boots [PRAFO (pressure relief ankle foot orthosis boot)] on while out of bed.
The plan of care for activities of daily living directed the resident required assistance of two staff for toileting and called for assistance with toileting needs. Staff promptly assisted the resident. The resident called for assistance from staff for toileting and staff assisted promptly.

Nursing note dated 11/9/15 at 4:45 P.M. documented the resident was oriented to person and family and had impaired decision-making. The resident was not ambulatory, exhibited poor coordination, and required extensive assistance of two staff members for transfers and toileting.

Nursing note dated 11/9/15 at 9:35 P.M., recorded staff heard the resident call and found the resident lying on his/her right side outside the bathroom door, the resident fell trying to get to the bathroom.

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Review of the facility provided investigation documented the intervention to move the resident closer to the nursing station as he/she was confused and unable to remember the use of the call light.

The investigation lacked any root cause analysis for the reason of the resident's fall.

Nursing note dated 11/9/15 at 11:25 P.M. documented the staff obtained a physician order and transferred the resident to the emergency room for evaluation and treatment.

Nursing note dated 11/10/15 at 2:17 A.M., documented the resident returned from the emergency room with no new orders, and staff moved the resident to a room closer to the nursing station.

A skilled nursing note dated 12/16/15 at 10:46 A.M. documented the resident received skilled service for right great toe amputation, had impaired decision-making, and was not ambulatory. The resident had generalized weakness affecting balance, and required extensive assistance of two staff for transfers and toileting.

Nursing note dated 12/19/15 documented at 4:15 P.M. the resident had some confusion and rested in a chair after his/her [family] left the resident ' s room. Nursing staff visualized the resident at 4:20 P.M. resting in his/her recliner. At 4:25 P.M. nursing staff entered the room to get the resident up. As nursing staff entered the room, the resident stood and fell to the floor before staff could get to him/her. Nursing staff assessed the resident with a golf-ball sized raised area to left

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forehead. When staff asked the resident what he/she was trying to do, the resident stated he/she was, "trying to get to that fire". Intervention added on 12/19/15 directed staff to increase visual checks to every 15 minutes for two hours after the resident's family left.

A facility investigation dated 12/21/15 documented the resident was confused, with a BIMS score of 6 (which indicated severe cognitive impairment), tended to hallucinate (sensing things while awake that appear to be real, but the mind created), transferred with extensive assistance of two staff and had a diagnosis of vascular dementia. The resident had a visit with his/her [family] had been in bed, and assisted up into the recliner after using the bathroom. The resident had pressure-relieving boots on. At 4:20 P.M. the resident asked for assistance getting up. Nursing staff went to get help, then found the resident trying to get up alone, Prafo boots still on and got caught in the recliner, fell forward and hit his/her head on the front right side. A goose egg appeared, staff obtained physician orders to send the resident to the emergency room. A CT scan (computed tomography-test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) at the acute care hospital revealed an inoperable small subdural hematoma and the resident remained at the hospital.

The facility report revealed the intervention to do staff education and not to leave the resident if he/she appeared confused, but rather to put on the call light and wait for help instead of leaving a confused resident to get assistance. Interventions added on 12/21/15 directed no black PRAFO boots on while out of bed. The

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facility failed to identify the root cause analysis of the resident's fall.

Review of the clinical record documented the resident remained in an acute care hospital from 12/19/15 to 12/29/15.

Review of an hospital discharge summary dated 12/29/15 documented the resident presented from nursing home after he/she fell out of his/her wheelchair and hit his/her head on a concrete floor. The resident was awake, alert, oriented to person but not place, time or situation. The resident does not remember the fall today. He/she cannot recall where he/she lives. The resident does not remember what he/she had for lunch. On admission, the resident showed a right parietal subarachnoid hemorrhage (the result of a blood vessel bursting in the subarachnoid space-which is the area just outside of the brain. This causes the area to quickly fill with blood) and trace bilateral subdural hematomas (collection of blood on the surface of the brain), and left frontal scalp hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma).

Nursing note dated 1/7/16 at 4:30 P.M. documented the resident with impaired decision-making, verbal with inappropriate/confused speech, difficulty making him/herself understood. The resident had an unsteady gait, poor trunk control, generalized weakness, and lower extremity weakness affecting balance, and poor coordination. The resident required extensive assistance of two staff for transfers, toileting, and grooming.

Nursing notes recorded the facility discharged the

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resident on 1/21/16 to the resident [family] ' s home.

On 2/12/16 at 6:30 A.M. direct care staff V reported the resident was alert to self, some confusion, and talked to the television. The resident recently had a toe amputated and required two staff for transfers.

On 2/12/16 6:30 A.M. licensed nursing staff L reported the resident was not always alert and oriented, and required assistance of two staff for activities of daily living. The resident went home with his/her [family].

On 2/12/16 at 3:11 P.M. direct care staff W reported the resident sometimes became confused and on 12/19/15, staff assisted the resident to the bathroom before his/her [family] left and then back into the recliner. The resident wore " those black boots " (PRAFO) usually just in bed. Nursing staff told us to put them on the resident, put his/her feet up, and the resident needed to wear the boots. The other staff had been in the resident ' s room a couple times and reported staff needed to get the resident up; he/she was kind of confused. The other staff went to get a drink and then I went to the door, just as the resident pushed the call light observed the resident attempting to get up, one of the black boots caught in the middle of the footrest and staff could not reach the resident as he/she toppled overhead first to the floor. Staff had moved the resident closer to the nursing station for his/her fall risk.

On 2/12/16 at 4:55 P.M. direct care staff X revealed the resident had been up in the recliner and his/her family just left. Direct care staff X

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reported he/she heard the resident's call light, went in immediately, and told the resident he/she would get help. The call light then rang again and as the other staff went into his/her room, the resident was trying to get up, boot caught on the recliner, and he/she fell. The resident was talking about the fire and needing to get the kids inside.

The facility provided policy Fall Prevention and Management dated February 2014, documented when the resident expressed a need, the staff should assist the resident promptly or immediately find another staff member that can perform the task for the resident. It was the responsibility of all staff to stay alert to these specific residents and report to the nursing staff immediately when a high-risk resident was or attempted to ambulate or transfer without assistance. The policy directed that staff performed an assessment to identify contributing factors for the fall. Staff conducted a post-fall huddle, involving all staff from the neighborhood, to identify causative factors and develop interventions to reduce the risk of further falls, and continued to ask "why" until staff identified a root cause. Staff communicated fall occurrence and interventions implemented to all pertinent staff.

The facility failed to provide supervision and assistive devices to prevent this cognitively impaired dependent resident identified as a fall risk from experiencing an avoidable fall with the injury of and inoperable subdural hematoma.

- The electronic clinical face sheet documented resident #9 with diagnoses that included macular

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degeneration (progressive deterioration of the retina), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heart beat), and cardiac pacemaker.

The annual Minimum Data Set (MDS) Assessment dated 8/25/15 recorded the resident with a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The resident required extensive assistance from staff for activities of daily living.

The Care Area Assessment dated 9/6/15, documented the resident with a self-care deficit and required extensive assistance of two staff and a full body lift for transfers, decline from a sit-to-stand lift, and received physical/occupation therapy to improve activities of daily living.

The quarterly MDS dated 11/4/15 recorded the resident with a BIMS score of 11, which indicated moderate cognitive impairment. The resident required extensive assist with all activities of daily living except eating, and exhibited unsteady balance and only able to stabilize with staff assistance.

The resident's comprehensive plan of care dated 11/12/15 directed the resident required two staff extensive assistance with a sit to stand lift for transfers and use a sling. The staff assessed the resident at risk for skin impairment/pressure ulcers and documented staff used an over the toilet commode for seat riser, repositioned the

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resident every hour and a toileting habit scheduled for toileting every 1-2 hours during the day.

A facility investigation dated 1/27/16 documented the resident had moderately impaired cognition, required two staff and extensive assistance with transfers and a sit to stand lift for bed mobility and toileting. The report documented on 1/25/16 at 5:20 P.M. nursing staff found the resident asleep on the bedside commode holding the call light. The facility observation camera documented on 1/25/16 at 12:40 P.M. direct care staff N and O entered the resident ' s room and then shortly left. The observation camera documented at 5:20 P.M. licensed nursing staff H entered the resident's room, (4 hours and 40 minutes since staff last observed, and checked the resident).

A bowel and bladder assessment dated 1/28/16 documented the resident required two staff with extensive assistance and the standup lift toileted the resident 30 minutes prior to 7 A.M., 9:30 A.M., 11:45 A.M., 3 P.M. and 6 P.M.

A nursing skin assessment dated 1/26/16 at 4:36 P.M. documented the resident with non-blanchable redness to the left buttock with an area that measured 6 centimeters (cm) by 3 cm. and placed the resident on a one-hour side-to-side repositioning schedule.

A nursing note dated 1/28/16 time 8:04 P.M. documented, on 1/25/16, evening staff found the resident, asleep, on the commode at 5:20 P.M. Staff assessed the resident with a ring of blanchable redness around the buttocks.

Observation on 2/10/16 at 3:10 P.M. revealed

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direct care staff M and N performed shift change rounds, and checked residents in rooms during shift change from 7 A.M./3 P.M. shift to 3 P.M./11 P.M.

On 2/10/16 at 4:38 P.M., direct care staff M revealed the resident required assistance of two staff for transfers.

On 2/12/16 at 7:20 A.M. licensed nursing staff G revealed the resident required two staff and the sit-to-stand lift to transfer to the commode. License nursing staff G reported the staff checked on residents at least every 30 minutes when walking the hall and direct care staff should have reported the resident was on the commode.

In a statement on 1/24/16 (sic 1/25/16), direct care staff M reported he she walked the floor and received report at 2:45 P.M. that indicated the resident was in bed. Direct care staff M did not visually check on the resident.

In a statement on 1/25/16, direct care staff Q reported at approximately 2 P.M. he/she observed direct care staff N and O take the resident to his/her room for toileting.

In a statement on 1/25/16 at 5:20 P.M., licensed nursing staff H revealed direct care staff P reported he/she found the resident on the commode in his/her room and no evening staff placed the resident on the commode.

In a statement on 1/26/16 direct care staff O (worked 7AM/3PM shift) revealed he/she and direct care staff N placed the resident on the commode (on 1/25/16) and gave the resident his/her call light.

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| F 323 | Continued From page 57<br><br>In a statement on 1/26/16 direct care staff N (worked 7AM/3PM shift) revealed he/she assisted direct care staff O and placed the resident on the commode. Direct care staff O reported staff gave the resident the call light. Direct care staff O never saw the resident's light go off and assumed that while on break, other staff assisted the resident from the commode.<br><br>In a statement on 1/28/16, direct care staff P revealed on second shift (3 P.M./11PM) he/she found the resident on the commode.<br><br>On 2/12/16 at 11:50 A.M. administrative nursing staff D expected staff to check on the resident at least every 15 to 30 minutes.<br><br>Review of the facility provided policy Bedside Commode, Offering/Removing, dated October 2010 lacked direction to staff on when to check residents on the bedside commode and how long to leave the resident without checking.<br><br>Review of the facility provided policy Preventing Resident Abuse, dated 4/24/14, included in staff training, recorded the signs of actual physical neglect included inadequate provision of care and leaving someone unattended who needed supervision.<br><br>The facility failed to provide assistance and supervision for this cognitively impaired dependent resident and left the resident on a commode for 4 hours and 40 minutes. | F 323 | | |
| F 353 SS=F | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS | F 353 | | 3/12/16 |

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The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 176 residents. Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Findings included:

- Observation on 2/10/16 at 1:00 P.M. resident #12 sat in a wheelchair at the medication cart and stated to licensed nursing staff G, he/she was

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waiting for someone. Intermittent observations revealed resident continued seated in the wheelchair at the medication cart, and at 3:19 P.M. the resident asked direct care staff if he/she could help. Direct care staff Y stated, " I can ' t help you right now. I am working with (an unsampled resident). You will have to grab one of the nurses. "

On 2/10/16 at 3:40 P.M., another unsampled resident used the call light and direct care staff Y answered. The resident reported to staff he/she was missing an item of clothing and not getting it back. The resident requested staff to go down now and look for the item. Direct care staff Y stated, " I don ' t have time right now. " Direct care staff Y then closed the resident ' s door and went down the hallway. At 3:45 P.M., the unsampled resident opened up the room door and looked out into the hallway.
During an interview with the unsampled resident on 2/10/15 at 3:50 P.M., he/she reported, " the staff did not seem to be able to help you and you can ' t find anyone. You can put on your light, they come and then leave. "

On 2/10/16 at 1:40 P.M. a confidential interview with an unsampled resident revealed staff timely assistance depended on the day.

On 2/10/16 at 2:00 P.M. licensed nursing staff JJ reported the day shift was missing a certified medication aide today.

On 2/10/16 at 5:18 P.M. direct care staff FF reported he/she worked two shifts today on two units for coverage.

On 2/10/15 at 3:52 P.M. direct care staff GG

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revealed he/she was working on two separate units passing medications on the evening shift because the licensed nurse could not get into the computer system.

On 2/10/16 at 4:38 P.M., direct care staff M reported many residents need two staff for transfers and usually have two direct care staff on the hall in the evening. Direct care staff M reported the facility scheduled a float staff tonight from another unit.

On 2/11/16 at 9:50 A.M. a confidential interview with an unsampled resident reported concerns with the slow operations of staff. I think they have lost control, have no systems and not enough staff.

On 2/11/16 at 1:30 P.M. administrative staff A reported the facility was working on the staff scheduling system.

On 2/12/16 at 1:10 P.M. a confidential interview with an unsampled resident revealed staff had to wait for assistance with cares due to a problem with staffing.

On 2/12/16 at 3:10 P.M., a confidential interview with an unsampled resident revealed the facility had plenty of staff for assistance, if you liked to wait 25 minutes.

Review of the facility provided nursing schedule for the week 2/7/16 through 2/13/16 proved difficulty to determine when a nurse worked more than one unit for coverage.
According to the schedule Norwich hall had no licensed nurse scheduled on 2/12/16 and 2/13/16 from 11 P.M. to 7 A.M.

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Westminster hall no licensed nurse scheduled on the 11 P.M. to 7 A.M. shift on 2/13/16.
York hall had no licensed nurse scheduled on the 11PM to 7 A.M. shift on 2/13/16.
Sunflower and Cambridge hall on Eastminister had no licensed nurse scheduled on the 11 P.M. to 7 A.M. shift for 2/12/16.
Elmhurst on 2/12/16 documented a licensed nurse from 10:45 P.M. to 3:15 A.M. The schedule lacked evidence of coverage from 3:15 A.M. to 6:45 A.M.

During a tour on 2/12/16 from 6:08 A.M. to 7:30 A.M. revealed one licensed nurse covered two distinct units on part of the building and a 11 P.M. to 7 A.M. nurse scheduled on another hall left prior to shift report.

On 2/12/16 at 6:20 A.M. licensed nursing staff I reported working on 2 separate units tonight, sometimes covers 3 units. Coverage on which unit depended on if there was a resident emergency.

On 2/12/16 at 8:52 A.M. direct care staff U reported concerns about staffing. Direct care staff U reported many residents require two staff for transfers and mechanical lift. Staff on duty had to search to find another staff member to assist with the resident or the resident had to wait. Occasionally a float staff was assigned to an area with two halls, however, rarely worked on both halls. The residents have to wait for help.

On 2/12/16 at 8:50 A.M. direct care staff S reported the unit lacked enough staff and the residents had to wait for assistance. Overnight the Sunflower unit, Elmhurst unit and Norwich unit share the same night nurse and staff were

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not able to provide cares.
Review of the census recorded Sunflower unit with 18 residents, Elmhurst unit with 28 residents and Norwich with 26 residents for a total of 72 residents.

On 2/12/16 at 9:10 A.M. licensed nursing staff J reported frequently staff were pulled to other units and have had only one direct care staff per hall and many of the residents required assistance of two staff for transfers and care. Licensed nursing staff J revealed on the morning of 2/11/16, the night shift nurse left without report, or count and staff did not know who was scheduled to cover that unit.

On 2/12/16 at 11:54 A.M. administrative nursing staff C reported he/she was unsure of the facility staffing standards.

On 2/12/16 at 3:45 P.M., licensed nursing staff K while assigned to one unit in the evening, another unit frequently called and reported they had no nurse coverage.

On 2/16/16 at 8:50 A.M. direct care staff R reported on some units the 11 P.M. to 7 A.M. shift frequently had two staff and no licensed nurse on the unit. Staff had to call another unit to summon a licensed nurse when a resident fell.

Review of the updated resident census list on 2/12/16 recorded a total census of 170 residents. The facility identified 55 residents that required two to one assistance with transfers or transfers with lifts.

Based on observation, interview, and record review, the facility failed to provide supervision

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| F 353 | Continued From page 63<br>and assistive devices to prevent accidents for 6 of 8 residents reviewed. Resident #7, a cognitively impaired dependent resident identified as a fall risk, from experiencing an avoidable injury fall including multiple rib fractures and a wrist fracture; resident #10, a cognitively impaired dependent resident that experienced multiple falls including an avoidable fall which results in a neck fracture; resident #8 a cognitively impaired dependent resident that experienced a fall that resulted in an inoperable subdural hematoma; resident #11 a cognitively impaired dependent resident dropped from a mechanical lift and experienced a compression fracture of the lumbar spine; resident #1 identified at risk for falls and unsteady balance, transferred without a gait belt as planned, fell and experienced a hematoma; and resident #9 a cognitively impaired dependent resident left unsupervised on a commode for 4 hours and 40 minutes. Refer to F323 for more information.<br><br>The facility failed to provide sufficient staffing to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. | F 353 | | |
| F 520 SS=F | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. | F 520 | | 3/12/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175340 | A. BUILDING _____ B. WING _____ | C 02/22/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALDERSGATE VILLAGE | 3220 SW ALBRIGHT DRIVE TOPEKA, KS 66614 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 520 | Continued From page 64 | F 520 | | |

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 176 residents. Based on observation, interview, and record review, the facility failed to maintain an effective quality assurance committee (QAA) that developed and implemented appropriate plans of action to correct identified quality of care and quality of life concerns for all residents of the facility.

Findings included:

- On 2/12/16 at 12:55 P.M. administrative staff A reported the quality assurance committee met every month to discuss risk findings and concerns.

The facility failed to maintain an effective quality assurance committee to meet the physical, mental and psychosocial needs of the 176

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|---|---|---|---|---|
| F 520 | Continued From page 65<br>residents as evidenced by:<br><br>1. Failure to provide quality of life for residents as evidence by the following:<br><br>a) Refer to F280. Based on observation, interview, and record review, the facility failed to review and revise care plans for resident #3 placed in isolation for infection and resident #6 who experienced a significant change of condition with activities of daily living.<br><br>2. Failure to provide quality of care for residents as evidence by the following:<br><br>a.) Refer to F323. Based on observation, interview, and record review, the facility failed to provide supervision and assistive devices to prevent accidents for 6 of 8 residents reviewed. Resident #7, a cognitively impaired dependent resident identified as a fall risk, from experiencing an avoidable injury fall including multiple rib fractures and a wrist fracture; resident #10, a cognitively impaired dependent resident that experienced multiple falls including an avoidable fall which results in a neck fracture; resident #8 a cognitively impaired dependent resident that experienced a fall that resulted in an inoperable subdural hematoma; resident #11 a cognitively impaired dependent resident dropped from a mechanical lift and experienced a compression fracture of the lumbar spine; resident #1 identified at risk for falls and unsteady balance, transferred without a gait belt as planned, fell and experienced a hematoma; and resident #9 a cognitively impaired dependent resident left unsupervised on a commode for 4 hours and 40 minutes. | F 520 | | |

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|---|---|---|---|---|
| F 520 | Continued From page 66<br>b.) Refer to F353: Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care<br><br>The facility ' s quality assurance program failed to adequately address and implement a program to meet these identified resident care needs. | F 520 | | |